

regulations and must be submitted in accordance with general instructions issued by HCFA.

(b) *Denial of payment.* If HCFA finds that a physician or provider has failed to comply with paragraph (a) of this section, HCFA will deny payment for the implantation, removal, or replacement of any permanent cardiac pacemaker or pacemaker lead, effective 45 days after sending the physician or provider written notice in accordance with paragraph (c) of this section.

(c) *Notice of denial of payment.* The notice of denial of payment—

(1) States the reasons for the determination;

(2) Grants the physician or provider 45 days from the date of the notice to submit the information or evidence showing that the determination is in error; and

(3) Informs the physician or provider of its right to hearing.

(d) *Right to hearing.* If the denial of payment goes into effect at the expiration of the 45-day period, it constitutes an “initial determination” subject to administrative and judicial review under part 498 of this chapter.

[56 FR 8841, Mar. 1, 1991]

§ 410.66 Emergency outpatient services furnished by a nonparticipating hospital and services furnished in Mexico or Canada.

Conditions for payment of emergency outpatient services furnished by a nonparticipating U.S. hospital and for services furnished in Mexico or Canada are set forth in subparts G and H of part 424 of this chapter.

[53 FR 6634, Mar. 1, 1988; 53 FR 12945, Apr. 20, 1988]

§ 410.68 Antigens: Scope and conditions.

Medicare Part B pays for—

(a) Antigens that are furnished as services incident to a physician's professional services; or

(b) A supply of antigen sufficient for not more than 12 weeks that is—

(1) Prepared for a patient by a doctor of medicine or osteopathy who has examined the patient and developed a plan of treatment including dosage levels; and

(2) Administered—

(i) In accord with the plan of treatment developed by the doctor of medicine or osteopathy who prepared the antigen; and

(ii) By a doctor of medicine or osteopathy or by a properly instructed person under the supervision of a doctor of medicine or osteopathy.

[54 FR 4026, Jan. 27, 1989]

§ 410.69 Services of a certified registered nurse anesthetist or an anesthesiologist's assistant: Basic rule and definitions.

(a) *Basic rule.* Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist or an anesthesiologist's assistant who is legally authorized to perform the services by the State in which the services are furnished.

(b) *Definitions.* For purposes of this part—

Anesthesiologist's assistant means a person who—

(1) Works under the direction of an anesthesiologist;

(2) Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and

(3) Is a graduate of a medical school-based anesthesiologist's assistant educational program that—

(A) Is accredited by the Committee on Allied Health Education and Accreditation; and

(B) Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.

Anesthetist includes both an anesthesiologist's assistant and a certified registered nurse anesthetist.

Certified registered nurse anesthetist means a registered nurse who:

(1) Is licensed as a registered professional nurse by the State in which the nurse practices;

(2) Meets any licensure requirements the State imposes with respect to nonphysician anesthetists;

(3) Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs,

or such other accreditation organization as may be designated by the Secretary; and

(4) Meets the following criteria:

(i) Has passed a certification examination of the Council on Certification of Nurse Anesthetists, the Council on Recertification of Nurse Anesthetists, or any other certification organization that may be designated by the Secretary; or

(ii) Is a graduate of a program described in paragraph (3) of this definition and within 24 months after that graduation meets the requirements of paragraph (4)(i) of this definition.

[57 FR 33896, July 31, 1992]

Subpart C—Home Health Services Under SMI

§ 410.80 Applicable rules.

Home health services furnished under Medicare Part B are subject to the rules set forth in subpart E of part 409 of this chapter.

Subpart D—Comprehensive Outpatient Rehabilitation Facility (CORF) Services

§ 410.100 Included services.

Subject to the conditions and limitations set forth in §§ 410.102 and 410.105, CORF services means the following services furnished to an outpatient of the CORF by personnel that meet the qualifications set forth in § 485.70 of this chapter.

(a) *Physicians' services.* The following services of the facility physician constitute CORF services: consultation with and medical supervision of non-physician staff, establishment and review of the plan of treatment, and other medical and facility administration activities. Those services are reimbursed on a reasonable cost basis under part 413 of this chapter. Diagnostic and therapeutic services furnished to an individual patient are not CORF physician's services. If covered, payment for these services would be made by the carrier on a reasonable charge basis subject to the provisions of subpart E of part 405 of this chapter.

(b) *Physical therapy services.* (1) These services include—

(i) Testing and measurement of the function or dysfunction of the neuromuscular, musculoskeletal, cardiovascular and respiratory systems; and

(ii) Assessment and treatment related to dysfunction caused by illness or injury, and aimed at preventing or reducing disability or pain and restoring lost function.

(2) The establishment of a maintenance therapy program for an individual whose restoration potential has been reached is a physical therapy service; however, maintenance therapy itself is not covered as part of these services.

(c) *Occupational therapy services.* These services include—

(1) Teaching of compensatory techniques to permit an individual with a physical impairment or limitation to engage in daily activities.

(2) Evaluation of an individual's level of independent functioning.

(3) Selection and teaching of task-oriented therapeutic activities to restore sensory-integrative function; and

(4) Assessment of an individual's vocational potential, except when the assessment is related solely to vocational rehabilitation.

(d) *Speech-language pathology services.* These are services for the diagnosis and treatment of speech and language disorders that create difficulties in communication.

(e) *Respiratory therapy services.* (1) These are services for the assessment, diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies or abnormalities of cardiopulmonary function.

(2) These services include—

(i) Application of techniques for support of oxygenation and ventilation of the patient and for pulmonary rehabilitation.

(ii) Therapeutic use and monitoring of gases, mists, and aerosols and related equipment;

(iii) Bronchial hygiene therapy;

(iv) Pulmonary rehabilitation techniques such as exercise conditioning, breathing retraining and patient education in the management of respiratory problems.

(v) Diagnostic tests to be evaluated by a physician, such as pulmonary